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LGA health commission



*Local Government Association*

# accountability for health

a scoping paper for the LGA Health Commission



## **accountability for health**

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## **accountability for health**

a scoping paper for the LGA Health Commission by Tim Blackman, Gerald Wistow and Jonathan Wistow, Wolfson Research Institute, Durham University

**January 2008**

## **1. Introduction**

- 1.1 This paper for the LGA Health Commission aims to scope the main issues surrounding the accountability of health services in England in the context of the Commission's terms of reference<sup>1</sup>. These require the Commission to consider, against a background of what is referred to as a 'new consensus' about localism, how local councils might work best with NHS and other partners to engage local people in decision-making and empower them to hold the health care commissioning and delivery system to account.
- 1.2 In this paper, we seek to clarify the different ways in which accountability has been understood and expressed in relation to the NHS, and to offer a framework for assessing both current mechanisms and new proposals. The paper is organised into seven parts:
- Part 1 is the introduction.
  - Part 2 explores the historical background to the current debates.
  - Part 3 considers types of accountability.
  - Part 4 considers the new consensus said to support a more localist approach to public services.
  - Part 5 reviews current arrangements for accountability
  - Part 6 considers some recent proposals for improving accountability.
  - Part 7 concludes with some points that the Commission may wish to consider in assessing options.

## **2. The influence of history**

- 2.1 Existing patterns of accountability for health reflect historical influences which are deeply embedded in current institutions and positions on the issue. The nature and extent of accountability in the NHS was a major element in the negotiations which led to its creation in 1948. Bevan's preference for a single national hospital service, administered by special purpose appointed bodies, prevailed over Morrison's defence of municipal hospitals and local government control. The case against the latter option included the doctors' opposition and the inappropriateness of local authority boundaries for hospital planning.
- 2.2 Bevan's argument for national rather than local accountability is generally illustrated by his declaration that the sound of a dropped bedpan in an NHS ward should resound in Whitehall and Westminster. This position, however, was not a claim for national or political control over service delivery. As part of his strategy to secure the doctors' participation in the NHS he promised to provide them with 'all the facilities, resources, apparatus and help I can, and then leave you alone as professional men and women to use your skills and judgement without hindrance' (quoted in Webster, 1998, p. 30). The political and administrative state was to stop well outside the consulting room door.
- 2.3 For more than three decades, the NHS presented the paradox of an expanding nationalised service (community services and public health were transferred from local government in 1974) based upon minimal central hierarchy. Rhodes (1988) characterised governance in the NHS during this era as that of the archetypal 'professionalised network'

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<sup>1</sup> See: <http://www.healthcommission.lga.gov.uk/lga/core/page.do?pagelId=1>.

with a labyrinth of professional advisory structures and vetoes entrenched in consensus decision making.

- 2.4 This pattern of weak central control and self regulation through professional networks persisted into the 1980s. Annual accountability systems were introduced from 1982, but Griffiths' (1983) view was that a modern day Florence Nightingale wandering the corridors of the NHS would be trying to find who was in charge. Despite the implementation of his general management recommendations from 1985, a later White Paper (DH, 1989) contended that its proposals were intended to introduce for the first time 'a clear and effective chain of management command running from districts ... to the Secretary of State'.
- 2.5 Since then, the NHS has experienced attempts to re-mould accountability structures through internal markets, reinforced hierarchy centred on national targets, and the reintroduction of market mechanisms based on a mixed economy of supply. Accountability upwards for at least the last decade has focussed on reducing waiting times. Although (or perhaps because) these targets have met with a significant measure of success, albeit with some unintended consequences, this most recent period of NHS history has been accompanied by calls to end political interference and create an 'independent' NHS (British Medical Association, 2007; Clougherty, 2007; Glasby, Peck, Ham and Dickinson, 2007).

### **3. Accountability: a multifaceted concept**

- 3.1 Accountability is often regarded to be about ensuring that those who deliver public services are answerable to those who either finance or use them (Day and Klein, 1987). The reality, however, is more complicated. Accountability is a multifaceted concept and is shaped through different kinds of power by particular discourses. These make sense of accountability in different ways, implying particular ways of working as logical or appropriate (Newman, 2001). To unravel this it is useful to distinguish between five types of accountability:
  - (i) *Professional accountability* is based on a professional body setting the standards of practice that users can expect, and professionals being answerable to their peers for their performance against these standards. Although there remain high levels of public trust in health professionals, professional accountability in the NHS has been challenged by evidence of some large and inefficient variations in clinical practice and a number of high profile failings, notably the 'Bristol babies' case (Kennedy, 2001). Clinical practice has, as a result, been brought within the ambit of audit (see below) and with an expectation that patients are involved. Increased expectations by patients to share in decisions about their care, and from whom they receive care, have also challenged the idea that professionals should only be accountable to their peers. Nevertheless, expert knowledge is needed if any system of accountability for health is to be effective, given both the degree of specialisation and the autonomy that professionals still necessarily have.
  - (ii) *Audit* is used in this paper in the broad sense of performance assessment for the purpose of accountability. The expansion of audit beyond financial scrutiny alone has been driven by expectations of greater transparency and a suspicion of

'producer domination' of public services and organisational choices (Clarke, 2006). Auditable information is now required from all public services, forming part of comprehensive assessments of performance against standards and targets that are published and available for media and public scrutiny.

In England, the Healthcare Commission currently audits the performance of local NHS services, with financial scrutiny also undertaken by the Audit Commission. The Healthcare Commission's audits are wide-ranging and include assessing standards for working in partnership with local government and for patient and public involvement, as well as independent reviews of complaints. Given the need for public accountability to be based on clear objectives, audit has an important role in one form or another. To date, however, it has been closely related to managerial accountability upwards for performance, with national targets enabling comparison between organisations and putting poorer performers under pressure to improve. It has not, though, been very effective in improving accountability downwards and there is evidence that users and the public rarely scrutinise performance data (Smith, 2005).

Audit has been evolving, with recent attempts to reduce its burden and shift its focus, from scaling down data requirements and rationalising inspections - including giving 'earned autonomy' to highly performing organisations - to developing a single local area performance framework for public services called comprehensive area assessment (CAA). CAA is meant to be more relevant to local residents by focusing on what is identified as important to them about where they live and inviting their feedback using a 'place survey' (DCLG, 2007a).

- (iii) *Democratic control* in the UK has conventionally meant elected representatives holding professional officers to account and having the power to enforce decisions for which they are electorally accountable. There are institutional constraints on the exercise of this power, including various requirements to consult and judicial and central government powers of intervention. Direct democracy such as referenda is less common in England than some other countries, although a limited extension of direct democracy through strengthening the role of petitions is currently under consideration (DCLG, 2007b).

Democratic control has become more complicated with the delegation of decision-making powers to public bodies, a notable instance being the boards of NHS trusts. Primary Care Trusts undertake commissioning of health services for the local populations they serve from GPs, NHS provider trusts and other service providers. Despite their role in shaping local health service provision, they have no elected representation on their boards and their accountability can only be enforced by Strategic Health Authorities acting on behalf of the Secretary of State for Health (although they are expected to demonstrate how their commissioning decisions have been influenced by local consultation<sup>2</sup>). Some might argue that NHS providers that have successfully applied to the Department of Health to become foundation trusts have more democratic legitimacy than PCTs because of their 'mutual society' governance model. In addition, their relative autonomy has been argued as undermining integration within the NHS despite possible benefits for organisational

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<sup>2</sup> Local Government and Public Involvement in Health Act 2007.

efficiency and effectiveness (Mohan, 2003). While the expansion of foundation trusts from hospitals into primary and community health services might support service integration within the NHS, it may also accentuate issues about the legitimacy of PCT commissioning decisions that affect them.

Democratic control at different vertical and horizontal levels has the potential for conflict between levels, which can all claim democratic legitimacy. This at least partly reflects possible differences about the criteria employed to judge policies or actions, and the geographical scale at which particular decisions should be made.

Democratic control cannot be separated from an ongoing dialogue about these issues. Ultimately Parliament decides where authority and power reside, but given the scale and complexity of the NHS there is a need for clarity that is sometimes currently lacking.

- (iv) *Stakeholding* is about horizontal rather than vertical accountability and is based on agreements between organisations about common objectives. The concept is prominent in locality-based partnership initiatives such as Local Strategic Partnerships and is sometimes described as 'co-governance' (Johnson and Osborne, 2003). It has been embedded in the series of recent new or strengthened duties placed on local councils and PCTs to assess needs and commission services together and share objectives through LAAs. This is still, however, within a wider vertical accountability structure in which the authority and power to approve and review LAAs lies with Government Offices acting on behalf of central government departments. Gillanders and Ahmad (2007) comment on the round one and two LAA negotiations that there were 'deep differences between departments in their culture, ways of working, and existing relationships with localities. These variations made it hard for local partners, who have very different accountability relationships with central government departments, to work together locally' (p. 755). Where the co-governance of local health and social care services has extended beyond multi-agency partnerships to integrated commissioning teams and a single board, separate accountabilities are still legally required to the local council and the PCT, and upwards to different ministers. This has meant that tensions can occur regarding budgeting in particular; for example, when one organisation is under pressure to prioritise balancing its budget over a commitment to a shared priority with its partner, especially when this has a financial impact for the partner.

Stakeholding is an important basis for negotiation and agreement, but limited as an accountability mechanism. Devolving decision-making to a local partnership body does not resolve the issue if there is no clear public accountability (Audit Commission, 2005).

- (v) *Market mechanisms* to empower individual consumers of public services have developed from establishing commissioning organisations responsible for purchasing services on behalf of the public to offering users a choice of service providers and individual budgets for purchasing social care. Politically managed markets, designed to ensure equity and social justice, are a means of delivering individual-level accountability (Le Grand, 2007).

- 3.2 Any system of accountability for health services is likely to need elements of all five types of accountability. To add to the complexity, they will also play out in a context of two cross-cutting dimensions of governance. The first of these is the level at which authority and power are exercised: the *individual* level in several possible roles as a voter, user, non-user, purchaser, consultee, activist or complainant; the *sub-national level* of organisation and governance from regions to localities, neighbourhoods and individual organisations; and the *national level* of Government departments, agencies and Parliament (and beyond to the European Union and global authorities such as the World Trade Organisation).
- 3.3 As already noted, potential conflicts between these levels of governance require clarity about roles and responsibilities. For example, managers in highly performing hospitals may perceive PCTs as restraining their ability to improve services for patients and see foundation status, and the possibility of expanding into local primary care services, as opportunities to strengthen their position in relation to PCT commissioners (Russell, Goddard and Bate, 2007). There is considerable potential for confusion and ineffective accountability if authority and power is not clearly defined at each level. Any reform aimed at improving accountability therefore needs to offer clarity about authority and power, the levels at which they are exercised, and the means by which agreement between levels can be negotiated (Wistow, 2006).
- 3.4 The second dimension is how accountability is constructed on a scale from *answerability* for decisions to *enforcement* if a decision is found to be at fault. Answerability means that those who plan and deliver services are expected to furnish information and explain decisions when requested to do so by interested parties. It may be appropriate for accountability to stop there. Enforcement, however, takes this further so that accountability offers a means of redress. Any system of accountability needs to offer answerability but – within a framework of clarity about authority and powers – it will be more effective the better the means are to enforce improvements if services fail to meet their required standards or objectives.

#### **4. The new localism: local decisions within a framework of national standards**

- 4.1 The argument for a more localist approach to public services reflects a widespread view that public services reform needs to move on from a top-down approach (Barber, 2007). The initial phase of post-1997 reform involved a large number of national targets or 'guarantees' managed through processes of accountability upwards. This is giving way to processes that are meant to be less target-driven from the centre and more locally self-sustaining, but are introducing added complexity. More devolved decision-making is being combined with user and public involvement, more autonomy for higher performance, greater transparency, more choice and personalisation, and market mechanisms with 'payment by results' for providers.
- 4.2 The strategic role of local government in this new approach is cast as one of 'place shaping' (DCLG, 2006). This includes greater expectations of local authorities influencing decisions about health services and driving action to improve health and reduce health inequalities. The mechanisms for this include LAAs, joint strategic needs assessments for health and social care, joint appointments of senior managers and directors of public health, pooled budgets and joint commissioning. Reformed accountability mechanisms include a smaller number of national targets and a new outcomes framework for local



authorities and their partners, local involvement networks (LINKs), and new powers for overview and scrutiny committees. PCT duties to 'involve and consult' have been strengthened and a new duty has been placed on the NHS to cooperate with local authorities to support the latter's lead role in preparing LAAs consistent with local expressions of need<sup>3</sup>.

- 4.3 Lyons (2007) described this lead role as that of a 'convenor', but it is unclear what this means in practice for where the power and authority lie to make decisions about health and health-related services, to whom decision-makers are answerable, and with what consequences for either redress or enforcement. These are key issues as more autonomy is devolved to NHS trusts to make managerial and clinical decisions.
- 4.4 Although the LGA Commission's terms of reference assert the existence of a consensus on extending localism in public services, there is a lack of a full consensus between the NHS and local government systems on the purpose of localism. Both are debating the desirability of greater local accountability to those who use services and to the wider public. However, the new constitution for the NHS that is currently under development is driven by a view that 'the NHS could benefit from greater distance from the day to day thrust of the political process' (Darzi, 2007). By contrast, the new constitutional settlement between central and local government contains a commitment 'to increase local democratic accountability of key public services, in particular the police and health services ...' (Bleas and Milton, 2007). It might be possible to reconcile these two positions by regarding the *political process* as distinct from *local democratic accountability*. In reality it is very difficult to envisage local democratic accountability without a role for a locality's elected representatives in local government and Parliament. Moves to depoliticise decision-making in the NHS inevitably raise the question of at what stage and through what mechanisms there is accountability to an electorate<sup>4</sup>.

## 5. Current mechanisms

- 5.1 In this section, we identify the current arrangements for accountability for health and health services within the framework developed in section 3. Our approach, therefore, is to consider these with reference to five categories of accountability - democratic, audit, professional, stakeholding and markets - and three levels of governance - individual, sub-national and national. Figure 1 represents this diagrammatically with examples of some of the main mechanisms. Our aim is to provide a framework for more detailed exploration.
- 5.2 *Professional accountability* remains a powerful influence on service design and operational practice. However, the extent to which professional decision making has been challenged by political and managerial accountability structures is at least implicit in the calls for greater NHS independence. Gordon Brown's appointment to ministerial office of Ara Darzi, a Professor of Surgery, was also initially interpreted as reassuring clinicians that 'instead of having politicians or managers telling the health service what to do, he was putting one of their own in charge of mapping out the future'<sup>5</sup>. Darzi's interim report noted that 'staff often feel left out of the changes that are happening'. He recognised

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<sup>3</sup> Local Government and Public Involvement in Health Act 2007.

<sup>4</sup> It might be noted here that in New Zealand, where there are direct elections to two thirds of seats on district health boards, most candidates are independents (Ham, 2008a).

<sup>5</sup> John Carvel 'Starting from scratch', *The Guardian* Wednesday July 11, 2007

that, in some cases, this was because 'greater power for patients is challenging old ways of doing things'. In other cases, however, staff could 'see that changes need to be made. They now need the space to act on this'<sup>6</sup>.

- 5.3 *Audit.* Information in general has a critical role to play in all forms of accountability. Performance data gathered and published for audit exercises is of obvious relevance, but the exercise of choice and control by individual consumers is also dependent on access to information about the availability of supply and disinterested information about personal needs and their match with appropriate supply. Some degree of professional knowledge is commonly considered necessary to empower individuals to make decisions about their own care and hold services to account. The practice and PCT prospectus, information about provider services and performance data at the level of facilities and individual professionals all have a potential part to play here. In addition to auditing professional performance, feedback from patients and the public is an important aspect of assessing the performance of commissioners and providers.

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<sup>6</sup> Lord Darzi, *Our NHS, Our Future*, DH 2007, p.15

**Table 1. Current types of accountability by level of governance**

Type of accountability	Level of governance		
	<i>Individual</i>	<i>Sub-national</i>	<i>National</i>
<i>Professional</i>	<ul style="list-style-type: none"> <li>• Duty of care</li> <li>• Clinical governance</li> </ul>	<ul style="list-style-type: none"> <li>• Professional appointments to NHS boards</li> <li>• Professional advisory committees</li> <li>• Local Medical Committee</li> <li>• Clinical governance</li> </ul>	<ul style="list-style-type: none"> <li>• Royal Colleges and other professional, regulatory and accreditation bodies</li> <li>• General Medical Committee</li> <li>• Independent Review Panel</li> <li>• Clinical governance</li> </ul>
<i>Audit</i>	<ul style="list-style-type: none"> <li>• Clinical governance</li> <li>• Complaints</li> <li>• Appeals on treatment exclusions and deregistrations</li> <li>• Patient and public surveys</li> </ul>	<ul style="list-style-type: none"> <li>• Health and Audit Commission performance assessments</li> <li>• Comprehensive Area Assessments</li> <li>• Strategic Health Authorities</li> <li>• Audit Commission and NAO studies</li> </ul>	<ul style="list-style-type: none"> <li>• National Service Frameworks</li> <li>• National standards and objectives</li> <li>• NICE</li> <li>• Health and Audit Commission reviews</li> <li>• National Audit Office reviews</li> </ul>
<i>Democratic</i>	<ul style="list-style-type: none"> <li>• General elections</li> <li>• Local elections</li> <li>• Elections to foundation trusts</li> <li>• Consultation and involvement</li> </ul>	<ul style="list-style-type: none"> <li>• Local government</li> <li>• Overview and scrutiny committees</li> <li>• LINKs</li> <li>• MPs</li> <li>• Consultation and involvement</li> </ul>	<ul style="list-style-type: none"> <li>• Parliament</li> <li>• Parliamentary committees</li> <li>• Ministerial responsibilities</li> <li>• Independent Review Panel</li> </ul>
<i>Stakeholding</i>	<ul style="list-style-type: none"> <li>• Expert patient/expert carer programmes</li> <li>• Membership of foundation trusts and social enterprises</li> <li>• Membership of community and voluntary organisations</li> </ul>	<ul style="list-style-type: none"> <li>• Local Strategic Partnerships, Sustainable Community Strategies and LAAs (including national and local targets)</li> <li>• Health and well-being partnerships</li> <li>• Duty of cooperation</li> <li>• Section 31 agreements</li> <li>• Joint strategic needs assessments</li> </ul>	<ul style="list-style-type: none"> <li>• Working and reference groups</li> <li>• Health and well-being commissioning framework</li> <li>• Joint outcomes and accountability framework</li> </ul>
<i>Market</i>	<ul style="list-style-type: none"> <li>• Choice of GP</li> <li>• Choose and book</li> <li>• Practice prospectus</li> <li>• Advocacy and decision-making support</li> <li>• Data on clinical performance</li> </ul>	<ul style="list-style-type: none"> <li>• Practice Prospectus</li> <li>• Primary Care Trust Prospectus</li> <li>• Market management</li> <li>• Contracts</li> </ul>	<ul style="list-style-type: none"> <li>• Market management</li> <li>• Standard contracts</li> </ul>

Three other features of national accountability may be highlighted here: the development of National Service Frameworks (NSFs) based on best available evidence and professional engagement informing expected standards of practice; the establishment of the National Institute for Health and Clinical Excellence (NICE) to provide evidence-based reviews of drugs and procedures to inform local commissioning and clinical decision-making regarding cost-effectiveness; and the introduction of clinical governance processes to oversee the quality of clinical practice. While each of these has had strong professional leadership, they each represent mechanisms which in different ways seek to reduce variations in practice that cannot be justified by the best available evidence. They are therefore mechanisms that seek to make the local NHS accountable for meeting national standards of practice and evidence.

- 5.4 *Democratic control.* Accountability to individuals is exercised through the ballot box in general elections and local elections, the former being the only form of direct, democratic accountability in the NHS. It is not uncommon for health matters to become major issues at local elections (and more rarely for individuals or groups to be returned on such platforms) but local government's powers relate principally to answerability rather than enforcement. Individuals who choose to become members of foundation trusts may stand as and vote for governors, though on a substantially smaller franchise.

Despite the lack of elected NHS bodies, electoral accountability is not entirely absent at sub-national level. Health and health services form a significant part of constituency business and case work for MPs. Without ministerial support, however, MPs' powers are limited to those of answerability rather than enforcement. In principle, democratic influences can be exercised indirectly through the community leadership and scrutiny roles of local authorities and their formal rights to be consulted about NHS changes. LINKs also have a potentially important part to play in facilitating patients' and public voice (Hogg, 2007). In practice, though, these powers are weak compared with those of top-down enforcement to which NHS managers and boards are subject at local and SHA levels, and which constitute by far the most powerful form of sub-national accountability for the NHS. Local government scrutiny committees are to some extent a means of exercising local democratic influence over the NHS, but they have few formal powers to enforce recommendations and often few resources to support their inquiries with research and evidence (Centre for Public Scrutiny, 2007).

Local residence is no longer a requirement for membership of local NHS boards, and boards are not intended to be either representative of the local public or representatives of it. The Appointments Commission was established at arms length from ministers to 'de-politicise' the appointments process, though as a non-departmental public body ministers remain ultimately responsible for its performance and effectiveness (Cabinet Office, 2007). The recent resignations of the chair and non-executive directors of the Maidstone and Tunbridge Wells Hospital Trust following 90 deaths from infections also demonstrates that Board members who have, rightly or wrongly, lost ministerial confidence find it difficult to continue<sup>7</sup>.

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<sup>7</sup> Indeed, the chair wrote to the Secretary of State to say that he could only remain in post if he had his confidence. The following day, the Secretary of State told the Commons that he had accepted the chair's resignation (Parliamentary Debates 2007, Moore 2007). A further feature of this case is the Opposition's criticism of the Health Secretary for not using his powers to dismiss the whole Board (Carvel 2007).

The principle feature of accountability at national level has been the development of hierarchical controls based on national targets. While targets are generally seen to have been effective in reducing waiting times, it is accepted that they have had some perverse effects and should be relaxed within a system focussed more on local accountability.

- 5.5 *Stakeholding.* Opportunities for individuals to influence health services and, in limited ways, hold them to account exist for 'active citizens' in community and voluntary associations, whether organised on a patient group or more generic neighbourhood basis. Such engagement may relate to commissioning processes or statutory consultations on major service changes. They may also be organised to provide self help, mutual support and fundraising functions. It is to some extent in recognition of the first two roles that expert patient and expert carer programmes have been established to contribute to direct patient care and as vehicles for secondary prevention. Their role highlights a further dimension of individual engagement in decision making and accountability processes: individual patients should expect to be treated with dignity as partners in their assessment and care on ethical and effectiveness grounds.

At a sub-national level, various stakeholding mechanisms represent attempts to align or otherwise combine the objectives and resources of the NHS, local government and other services to meet the needs of populations for which they share responsibility. The history of three decades of joint planning and commissioning between health and social care agencies is one of repeated re-launches and the re-design of incentives for behavioural change, of which the 2006 White Paper was perhaps the most comprehensive and subtle (DH 2006)<sup>8</sup>. There has been more progress with establishing joint processes than achieving different outcomes for local populations, and organisational restructuring and potentially competing imperatives such as choice of provider have disrupted and complicated joint working (McMurray, 2007; Hudson, 2007; Perides, 2007). In addition, vertical accountability processes have sometimes given greater emphasis to internal rather than partnership objectives and have proved to be too strong for horizontal accountabilities to be sustained.

In principle, LSPs, LAAs and Sustainable Community Plans provide a meta framework for securing national and local accountability for meeting local health needs within a structure of national standards and agreed priorities. The approach has been developed incrementally and evaluated independently at each stage. The NHS has been less extensively engaged in such developments, and the White Paper *Strong and Prosperous Communities* stated that the new approach would not affect PCT accountabilities to SHAs (DCLG 2006). However, some NHS indicators are part of the new local performance framework and single indicator set. The challenge will be two fold: first whether SHAs and Government Offices are themselves enabled to operate through a process of co-governance to support the delivery of common objectives rather than perpetuate separate and conflicting demands on local agencies; and, second, whether some degree of 'independence' for the NHS as advocated by Darzi (2007) and others (for example Edwards 2007) is interpreted as independence from such co-governance processes as well as from detailed political control nationally.

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<sup>8</sup> Department of Health, *Our Health, Our Care, Our Say*, The Stationery Office, London

- 5.6 *Market mechanisms.* Although often focused on the individual consumer, market development and support is also an aspect of accountability at sub-national level. The aggregate of individual choices has collective consequences, whether expressed through 'choose and book', practice based commissioning or individual budgets. PCTs are also responsible for ensuring the design of care pathways consistent with the results of strategic needs analysis. The aggregation of individual choices, if effectively expressed, may also de-stabilise existing supply structures and has to be managed. Again, PCTs have responsibilities for minimising disruptions to supply, responsibilities which may cut across their responsibilities to promote more flexible and less institutionally focussed care pathways in line with best evidence and professional practice. These are all decisions that could be argued need democratic accountability, and it should be acknowledged that democratic processes might well come into conflict with market mechanisms when, for example, a local service is no longer regarded by its provider as viable or safe.

## **6. Current proposals for reform**

- 6.1 There appears to be an appetite among both health professionals and the public for health services to be more accountable locally (NHS Alliance et al., 2006). Furthermore, to the extent that engagement in social networks and control over one's life are themselves health promoting experiences, then public involvement may be advocated on the grounds of personal wellbeing as well as democratic control. Similar arguments may be advanced in support of providing choice and control through market mechanisms. However, accountability arrangements differ in purpose as well as form, with different implications for the interests of different stakeholders. Using the same framework as in the previous section, current proposals for reform to improve the accountability of health services can also be considered along the dimensions of type of accountability and level of governance (see table 2). It is important, though, to note that these types may overlap, with a given arrangement having aspects of more than one type of accountability and spanning more than one level of governance.
- 6.2 *Professional accountability.* At a national level, professional accountability has returned as a governance principle for the NHS in proposals that it is run by a professional board with much less direct political control and a constitution (British Medical Association, 2007; Clougherty, 2007; Glasby, Peck, Ham and Dickinson, 2007). The terms of reference for Darzi's review envisage a shift to a new balance between different forms of accountability, requiring him to establish a vision for the next decade 'which is based less on central direction and more on patient control, choice and local accountability and which ensures services are responsive to patients and local communities'<sup>9</sup>. His interim report does not, however, consider direct democratic accountability at local level. Rather, it combines patient control and local accountability with clinical leadership. For example, it argues the need for 'changing the way we lead change – effective change needs to be animated by the needs and preferences of patients, empowered to make their decisions count within the NHS; with the response to those patient needs and choices led by clinicians, taking account of the best available evidence'.<sup>10</sup>

Darzi's principle mechanism for increasing accountability to patients and public is the working group of national experts to consider the 'scope, form and content of an NHS

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<sup>9</sup> Ibid. p. 9

<sup>10</sup> Ibid. p.16

Constitution or settlement'<sup>11</sup>. The issues identified for consideration by this group are primarily internal to the NHS. One is defined as strengthening 'the opportunity to work in partnership with other agencies to improve access and the integration of care' (although no mention of improving health or reducing health inequalities). Another requires the group to 'review the process for NHS appointments, in line with the *Governance of Britain* green paper'. It is notable that no reference is made to the democratic deficit in the NHS or the new central/local government concordat (see above).

- 6.3 *Audit*. The main proposals for audit relevant to accountability relate to increasing the relevance of performance data to local people, partly addressed by Comprehensive Area Reviews. CAAs will replace corporate assessments of local councils, joint area reviews and annual performance assessments of children and young people's services. They will focus on the LSP and assess performance using a combination of a national indicator set (including data from the place survey) and locally-determined performance management information. The national indicator set includes some shared health indicators, and more shared health priorities can be agreed at local level. The LGA (2006) has argued for a more radical shift in audit so that it is *primarily* driven by objectives derived from local public consultation and assessments are mainly based on feedback from users and the public. The principle appears accepted by both central and local government that there should be, to a greater or lesser extent, a stronger emphasis on what local people regard as important, whatever public service is responsible for it. Local accountability will therefore need to sit in a partnership body such as the LSP or be exercised through one organisation, most obviously the local authority. It has been argued that this could extend to formalising the role of local authorities as holding PCTs and other local public services to account, possibly including scrutinising or approving appointments to local boards and the power to appoint and dismiss chief executives<sup>12</sup>.

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<sup>11</sup> Ibid. p. 52

<sup>12</sup> As already proposed by the LGA chair, Sir Simon Milton.

**Table 2. Proposed types of accountability by level of governance**

Type of accountability	Level of governance		
	<i>Individual</i>	<i>Sub-national</i>	<i>National</i>
<i>Professional</i>	<ul style="list-style-type: none"> <li>• Individual clinicians more responsive to patient voice</li> </ul>		<ul style="list-style-type: none"> <li>• Professional NHS board and constitution</li> </ul>
<i>Audit</i>	<ul style="list-style-type: none"> <li>• Bigger role for patient and public surveys and other forms of individual feedback</li> <li>• More meaningful performance data for patients and public</li> </ul>	<ul style="list-style-type: none"> <li>• More locally-driven objectives and performance assessments</li> <li>• More earned autonomy for highly performing organisations</li> </ul>	<ul style="list-style-type: none"> <li>• Fewer national targets</li> </ul>
<i>Democratic</i>	<ul style="list-style-type: none"> <li>• Referenda and petitions</li> <li>• Elections to NHS boards</li> <li>• Deeper and wider consultation and involvement</li> </ul>	<ul style="list-style-type: none"> <li>• Transfer of NHS in whole or part to local government</li> <li>• Elected NHS boards (whole or part)</li> <li>• Local government representation on NHS boards</li> <li>• Local government performance assessments of NHS (with greater or lesser enforcement)</li> <li>• Local government scrutiny or approval of NHS appointments</li> <li>• Stronger and better-resourced overview and scrutiny committees</li> <li>• More powerful LINKs</li> <li>• Deeper consultation and involvement</li> </ul>	<ul style="list-style-type: none"> <li>• More strategic role for parliament and ministers</li> <li>• NHS constitution clarifying democratic roles at each level of governance</li> </ul>
<i>Stakeholding</i>	<ul style="list-style-type: none"> <li>• Extension of expert patient/expert carer programmes</li> <li>• Extension of foundation trusts and social enterprises</li> </ul>	<ul style="list-style-type: none"> <li>• Joint NHS and local government boards and trusts</li> <li>• Joint PCT/local council chief executives</li> <li>• Extension of foundation trusts</li> </ul>	
<i>Market</i>	<ul style="list-style-type: none"> <li>• Individual budgets</li> <li>• Extended choice and exit options</li> </ul>	<ul style="list-style-type: none"> <li>• More guidance, advocacy and support</li> <li>• More choice of providers</li> <li>• Capacity building, especially third sector</li> </ul>	<ul style="list-style-type: none"> <li>• Stronger market management</li> </ul>



6.4 *Democratic control.* Direct democracy such as referenda could be extended into decision-making about commissioning priorities. Direct elections to PCT boards are another option, either to boards in whole or part, but could fragment relations between local and national levels and with local government. A more integrated approach would be for local councillors to be represented on PCT boards. This was the situation that existed for their equivalent bodies prior to 1990 and is currently the case in Scotland and Wales. We have not been able to find evidence that local member representation makes a difference to the quality or public accountability of decision-making. It is probably best regarded in value rather than evidence terms: it is the principle of local democratic representation that is regarded as important in Scotland and Wales (Greer and Rowland, 2007). As integration with local government gathers pace in England, there may be an underlying momentum towards this approach. Joint council and PCT appointments are now common in public health and social services, and Herefordshire has recently pioneered a joint chief executive appointment under arrangements to integrate commissioning in a public services trust (Taylor, 2007). Under current legislation, the council and PCT must remain separate bodies with their different accountabilities, but the trust brings elected members into a strategic role in NHS commissioning (there are some similarities with Scottish Community Health Partnerships). However, while this model might be able to demonstrate better efficiency and outcomes, it does not strengthen local accountability beyond stakeholding.

The membership model of foundation trusts has been advocated as improving local accountability but also runs the risk of fragmenting governance in the NHS and with partners in local government, even though this model may be extended to local community health services and has been advocated for PCTs themselves (Rankin, Allen and Brooks, 2007). The introduction of foundation hospital trusts and provider initiatives such as social enterprises has intensified the issue of accountability for PCTs, as already noted. Strengthening the democratic legitimacy locally of both commissioning and providing organisations, therefore, needs to be accompanied by clarity about responsibilities (a possible role for an NHS constitution, including clarifying democratic control from the centre if the NHS continues to be funded from national taxation).

A radical development of these reforms would be to transfer the NHS to local government. This proposal includes a range of options from transferring some functions, most obviously public health, to transferring all NHS commissioning to local government, either with or without responsibility for delivering health services (which would otherwise remain with the NHS as a provider organisation). The argument for bringing local health planning, funding and commissioning under the control of local councils is set out by Glasby, Smith and Dickinson (2006) and includes claims that financial management, public involvement and communication are undertaken better by local councils. The main counter-arguments are that this could cause further disruptive reorganisation, swamp local councils' other work and intensify local-national tensions about priorities, given that it would be impossible for all decisions to be taken locally<sup>13</sup>. Historically, the main objection has been that funding for the NHS is currently raised nationally by central government with no local element, which is therefore where accountability should primarily lie.

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<sup>13</sup> This also raises the issue of democratic deficit at a regional level, where significant powers are exercised by Strategic Health Authorities.

- 6.5 *Stakeholding.* An alternative to democratising the NHS itself is to increase its horizontal accountability to local government as an elected body. This could include strengthening the role of local councils in the LAA process and increasing the authority and power of overview and scrutiny committees and LINKs. Joint boards and trusts, with shared senior appointments, could also be regarded as strengthening stakeholding rather than democratic control.

Whatever governance arrangements are adopted there are persuasive arguments for improving accountability by developing new and sustained ways to involve patients and the public as stakeholders, especially moving beyond just representative structures to deeper involvement such as in the co-design of services and care pathways (Shah and Goss, 2007). More deliberative mechanisms have also been called for, such as citizen's juries and patient participation groups attached to commissioning practices. The representativeness of patient and public involvement is an issue that requires attention, however, especially making sure there is good 'outreach', from using community development workers or health trainers to deploying methods such as surveys and mystery shoppers.

- 6.6 *Market mechanisms.* Some have argued that extending individual budgets into health care would democratise the NHS by directly empowering users (Glasby and Duffy, 2007). The option is being seriously considered, although currently only for people with long-term conditions, where it is seen to have potential to achieve the same benefits that have been reported for social care of improved efficiency and enhanced user satisfaction and outcomes (Gainsbury, 2007). The main concerns about this approach relate to equity. Some people's choices may be poorly informed and the best providers may end up choosing who they serve on grounds other than need (Six, 2007). Ham (2008b) has also recently argued that it is not choice about individual services that is needed but choice between integrated care providers that are incentivised to provide all or most of the care a person needs and to avoid hospitalisation.

## **7. Conclusion**

- 7.1 The Commission's terms of reference invite it to consider how local councils may work best with NHS and other partners to engage people in decision making and empower them to hold commissioning and delivery systems to account. We have identified a range of ways in which such engagement and empowerment currently take place and might do so in future. In so doing, it has become clear that there is a substantial body of opinion favouring a shift in the balance between national and local accountability. There is less consensus about the extent to which power should shift towards which interests at local level: patients, the wider public, professionals or local government for example. In addition, there may be a need for more clarity about how greater independence for the NHS sits with the greater interdependence and integration of public services locally, which underpins the Lyons concept of place making and other aspects of the Local Government and Public Involvement in Health Act 2007.
- 7.2 Among the implications for the Commission of our discussion above, we would summarise the following:

- The extent of consensus about the implications of 'new localism' for the NHS and local government is questionable given calls for the NHS to be 'independent', with accountability primarily to individual patients exercising choice about their care;
- Although different concepts and forms of accountability compete and collide at different levels in the national and local worlds of the NHS and local government, elements of all of them are likely to be needed for accountability to be successful and inclusive;
- The Commission's recommendations may need to argue for (re)balancing the different types of accountability and their associated authority and power (from answerability to enforcement) at each level of governance. An NHS constitution could have an important role in clarifying these aspects;
- Different forms of accountability potentially serve different interests. Wherever possible these should be made explicit within a framework of checks and balances (offered by the different types of accountability themselves).

7.3 There are two final issues to consider. The first is specific to thinking about accountability. We have suggested that different degrees of effectiveness in accountability mechanisms can be located along the answerability/enforcement continuum. The Commission's terms of reference specifically relate to public engagement and empowering the public to hold the NHS to account. If, for example, the NHS is to raise its game in its relationships with the public, as the Carruthers report<sup>14</sup> has argued, more attention may need to be focussed on the enforcement end of the continuum. Darzi's interim report also comments that many local consultations remain inadequate, and one way to improve this would be to make much more explicit - and to enforce - when and how patients and the public should be consulted.

7.4 Our second concluding point is wider and, in some respects, more fundamental. The *Governance of Britain* Green Paper (July 2007)<sup>15</sup> seeks to forge a new relationship between citizens and the state that might, in time, lead to a written concordat or constitution. The document identifies policing and health as two particular areas in which further steps are needed to make services feel more accountable to local communities. What, therefore, is the underlying purpose behind extending the influence of patients and the public in decision making and accountability processes? How far is it to improve the effectiveness of health and health related services, and how far is it to improve governance and strengthen democracy more generally? It is important, therefore, to locate the debate about accountability in and for health services within a wider framework than some discourses traditionally allow.

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<sup>14</sup> Sir Ian Carruthers' review of major changes in service provision, reported in David Nicholson's letter to NHS chief executives in February 2007.

<sup>15</sup> Secretary of State for Justice, *The Governance of Britain*, The Stationery Office, London

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For further information please contact  
the Local Government Association at  
Local Government House  
Smith Square, London SW1P 3HZ

or telephone LGconnect for all your LGA queries on  
020 7664 3131  
Fax 020 7664 3030  
Email [info@lga.gov.uk](mailto:info@lga.gov.uk)



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